

Breaking down barriers: exploring the potential for social care practice with trans survivors of domestic abuse

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Abstract

There is increasing recognition that domestic abuse takes place outside of the heteronormative paradigm of social life. This paper presents a discussion of the findings of doctoral research which explores trans people's experiences of domestic abuse, their social care needs and whether these are met by domestic abuse agencies. This paper foregrounds debate on the intersections of domestic abuse, trans communities and social care provision as this research, and previous studies, suggests that trans survivors do not seek out or benefit from social care intervention. Qualitative data, collected via narrative interviews, was collected

during 2012 from participants mainly located in the UK (two participants were based in the US). A total of twenty four interviews were undertaken with trans people ($n = 15$) and social care practitioners ($n = 9$). Data was examined using a voice-centred relational technique. Findings reveal that barriers are multiple and complex but work could be undertaken to encourage help-seeking behaviours. Barriers include: expectations of a transphobic response and ‘Othering’ practices; lack of entitlement felt by trans people; lack of knowledge/misunderstandings about trans social care needs; heteronormative bias of existing services; and practitioner attitudes fixed to notions about gender as binary. The paper ends by proposing a framework for practice with trans survivors which incorporates a person-centred, narrative approach.

Keywords: trans, transgender, domestic abuse/domestic violence, social care, narrative

What is known about this topic

- Trans people experience domestic abuse at least at the same rates as non-trans people
- Trans people do not access domestic abuse services, in particular, and social care services, in general
- Trans people feel socially excluded due to the entrenched heteronormative bias in various aspects of social life

What this paper adds

- Barriers to help-seeking are located within both the trans community and social care services
- Trans participants desire a narrative, individualised approach to social care intervention
- The domestic abuse sector is best placed to provide social care to trans survivors of domestic abuse

Introduction

Domestic abuse is now widely recognised as a pervasive social problem. The majority of discourse and intervention, however, is located within the heteronormative framework; frequently domestic abuse is uncritically interpreted and represented as male violence perpetrated against women (Donovan 2012, Donovan and Hester 2014). In this framing, heteronormativity refers to the way in which heterosexual identity and subjectivity is centred and privileged to the marginalisation of non-heterosexual ones; heteronormativity is a form of social regulation through which ‘institutionalised, normative heterosexuality regulates those kept within its boundaries as well as marginalizing and sanctioning those outside them’ (Jackson 2006, p.105). There is a small body of literature which concerns domestic abuse outside of this heteronormative model, yet trans perspectives are largely absent from domestic abuse discourse, in particular, and from social care discourse, in general (McClennen & Gunther 1999, Fish 2006, Mallon 2009, Mitchell & Howarth 2009, McDonald 2012). Indeed, Mitchell and Howarth (2009, p.61) observe that ‘there is almost a complete absence of research on accessing social care services for trans people’. In the context of domestic

abuse, trans people can be said to belong to the group of 'hidden victims' (Gelles 1997, p. 96).

Before moving to a discussion of the research methods and findings, it is useful to delineate my use of the term 'trans'. Throughout this paper I adopt the umbrella term 'trans'. This is not to intentionally bundle all trans identities and practices into one homogenous grouping, but rather it is an attempt to include the diversity of trans identities and practices which sit within, across or outside of the gender binary. As such, my use of 'trans' incorporates a perspective which is congruent with Whittle's (2006) assertion that:

A trans identity is now available almost anywhere, to anyone who does not feel comfortable in the gender role they were attributed with at birth, or who has a gender identity at odds with the labels 'man' or 'woman' credited to them by formal authorities. The identity can cover a variety of experiences. It can encompass discomfort with role expectations, being queer, occasional or more frequent cross-dressing, permanent cross-dressing and cross-gender living, through to accessing major health interventions such as hormone therapy and surgical reassignment procedures. (Whittle 2006, p. xi)

This definition alludes to temporality as trans identity and practice can incorporate permanent/impermanent gender crossings and trans identity may be experienced on social, psychological or somatic bases (Prosser 1998, Whittle 2006). Trans people relate to a range of identity labels including: trans/trans*; transgender; transsexual; transvestite; cross dresser; MtF; FtM; and genderqueer. My use of the label 'trans' encompasses all these and others. In addition, the term 'gender non-conformity' is used to respect those participants whose identity and practice transgresses the boundaries of binary gender.

Where the trans perspective is purported to be incorporated into research, often it is discursively subsumed into an overarching ‘lesbian, gay, bisexual and trans’ (LGBT) perspective which, arguably, renders the trans perspective – with its roots in gender diversity, not sexuality or sexual practices – invisible or obscured by others (Brotman *et al.* 2003). For example, Addis *et al.* (2009) completed a meta-narrative review of literature concerning the health, social care and housing needs of LGBT older people; a total of 66 papers or chapters were included in the review. The authors state ‘this review found no research which included results on transgender groups’ (Addis *et al.* 2009, p. 655). Ironically, throughout the paper Addis *et al.* (2009) continually refer to the LGBT community despite the acknowledged absence of a trans perspective.

Notwithstanding, there is a growing body of work which explores trans people’s experiences of domestic abuse with statistics indicating that trans domestic abuse occurs, at least, at similar rates as for non-trans people; that is, at a rate of one in four people across the duration of the life-course (Scottish Transgender Alliance 2008, Women’s Aid 2009, Roch *et al.* 2010, Brown 2011, Donovan 2012, Hester *et al.* 2012, Broken Rainbow 2013, Donovan and Hester 2014). In addition, the need for research which focuses on trans survivors has been implicated in other literature which explores the impact of transphobia, heteronormative bias and gender role stereotyping. It has been argued, that a combination of these can put trans people at risk as domestic abuse is not recognised and is stigmatised within the community itself (Balsam 2001, Hassounah and Glass 2008, Scottish Transgender Alliance 2008, Roch *et al.* 2010, Brown 2011, Hester *et al.* 2012, Turrell *et al.* 2012).

More substantial attention has been given to public violence (for example, hate crime) perpetrated against trans and gender non-conforming people (gender non-conformity is represented by identities and practices which transgress binary gender). The public sphere is where trans activism and discourse is located whereas abuse within the private sphere of the home has largely been neglected (Fish 2006). There is a double bind resulting from the emphasis trans activism has placed upon public violence in combination with the prevailing heteronormative model of domestic abuse. Both perpetuate the hidden nature of trans domestic abuse by diverting attention away from the notion that domestic abuse is a problem in trans people's relationships. Other factors impact upon the absence of trans people as users of social care and include: fear of discrimination (access being refused or restricted in some way); expectations of a transphobic response; the fear of outing; and stigmatization (Fish 2006, Whittle *et al.* 2007, Mitchell & Howarth 2009).

The narratives of trans survivors and domestic abuse practitioners provide a lens through which to explore some of the barriers to help-seeking and, ultimately, to accessing domestic abuse provision. These barriers are to be found at micro (individual), meso (community/organisational) and macro (structural) levels. They are embedded and entwined. The paper ends by considering the potentiality of domestic abuse agencies to enhance the formal support networks of trans survivors through a narrative approach to social care practice.

Methods

Aims of study

This study aimed to produce an account of trans people's perspectives and experiences of domestic abuse, their social care needs and whether these are addressed through social care intervention. The study was built around four research questions which explored the ways in which trans people narrate their experiences of trans identity and practice in relation to intimate, familial and other social contexts and how and why trans people experience domestic abuse within those contexts. The study also sought to identify the social care needs of trans people, who experience domestic abuse, and to examine whether these are met. The final question explored the barriers that trans people experience in accessing formal social care and in doing so hoped to identify some indications and recommendations for practice. This paper is concerned with this last question.

Design

A qualitative framework underpinned the research design. The epistemology and ontological approach were undergirded by a feminist social constructionist perspective and influenced by 'the poststructural turn' and more recent writings on a queer sociological approach (Seidman 1996, Hines 2007). Queer sociology adopts the view that social reality can be constructed, deconstructed and reconstructed. Additionally, queer sociology employs the key principles of poststructuralism (for example, social constructions emerge through discourses) whilst maintaining an emphasis on subjectivity (Seidman 1996, Hines 2006). A pluralistic approach to theory enabled a methodology which moved away from binaried and normative thinking in relation to gender and, thus, integrated trans and gender non-conforming perspectives.

Sample

A purposive sampling technique was supported by snowballing methods (Bryman 2012). Multiple strategies were employed to recruit participants including advertising through gender-based agencies, across virtual sites (forums), through direct contact with social/support groups and a city-based domestic abuse forum. A broad definition of the identity category 'trans' was employed so that trans participants could self-identify as trans, transsexual, as having a transsexual history, as genderqueer, or in any way other than cisgender (non trans). This included transsexual participants who differentiated between post- and pre-operative status. The social care practitioners who took part in this study reflected a variety of work positions (for example, counsellor, public health specialist, independent domestic violence advocate (IDVA), refuge worker, project manager).

Data collection

Twenty four interviews were undertaken in total with trans people ($n = 15$) and with domestic abuse practitioners ($n = 9$). Data collection was undertaken using narrative interviews which enabled the gathering of stories from trans people and social care practitioners with specialist domestic abuse knowledge. Collecting stories is congruent with social care research as Baldwin (2013, p. 3) claims that it is a profession 'so obviously narrative in nature'. Interviews were conducted either face-to-face ($n = 20$) or via email ($n = 4$). Face-to-face interviews were digitally recorded. Email interviews took place after a period of email communication (relationship-building). Two of the four were conducted with trans participants whom had previously met the researcher face-to-face but, for

convenience, the interviews took place via email communication. Due to the sensitive nature of the topic, all participants were well-versed with regards to the study's aims and research questions in order that consent was fully informed. As such, the interview schedules were brief and this also allowed for free-flowing narrative. The interview schedules are detailed in box 1 below.

Box 1

Interview schedule for trans participants

- Q 1 Please tell me about your experience of life as a trans person starting with your earliest experiences and tell me about how your trans identity and embodiment impacted upon relationships and family life.
- Q 2 Please tell me about your experience of or perspective on domestic abuse.
- Q 3 Please tell me about your experience of social care services or your views about how social care services could be made to be accessible for trans people.

Interview schedule for social care practitioners

- Q 1 Please tell me about your experience of supporting trans people who experience domestic abuse or your knowledge of any trans people who have accessed your agency's services.
- Q 2 Do you feel equipped to support trans service users?
- Q 3 What do you think are the barriers to accessing services for trans people who experience domestic abuse? How could services be more accessible?

Data Analysis

All digitally recorded interviews were transcribed and coded by the researcher. This was to enable the researcher to be *close* to the data. The interview data was analysed using the 'Listening Guide' (Mauthner and Doucet 2008). This method considers that a social actor is a relational being who is embedded within a

complex and broad web of social relations. The 'Listening Guide' steers the researcher through multiple readings in order to identify and explore the interconnections and interactions, at a reflexive level, with significant others and at the intersections with other structures (family, community). Multiple readings enhanced the rigour of the analytical process and, in addition, 'member validation' was employed as each participant was provided with the opportunity to check the content of their transcribed interview (Bryman 2012). In order to demonstrate the range of participant characteristics, in the discussion below participants are described by their self-identified gender identity or by their professional role.

Ethical considerations

The study was approved by the University of Sheffield's Ethics Committee. The sensitive nature of the research was acknowledged through the employment of strategies which enabled participants to suspend interviews or skip questions that were emotionally distressing. In addition, information about available channels of support was prepared before the fieldwork stage. To address my 'outsider' status as a non-trans researcher, a culturally sensitive strategy and process of self-education was enhanced by a continual process of reflexivity. Informed consent was gained from all participants and pseudonyms were used to ensure confidentiality and privacy.

Findings

Twelve trans participants had experienced domestic abuse whereas the other three had supported trans survivors. The narratives of trans participants indicated that none had accessed social care when experiencing any form of domestic abuse. In

addition, none of the domestic abuse practitioners had directly worked with trans-identified service users within the context of their current agency setting. However, it was acknowledged that trans people are, most likely, invisible and some may have accessed services, such as community-based support, without knowledge of or recognition for their trans identity and practices. Therefore, the potential for social care practice was considered. This section outlines three major themes: 'barriers to help-seeking behaviour: trans people's narratives'; 'barriers to help-seeking behaviour: practitioner's perspectives'; and 'messages for practice'.

Barriers to help-seeking behaviour: trans people's narratives

Four narrative themes are presented in this section: the insufficiency of minimum legal standards; praxis influenced by the gender binary; lack of entitlement as a belief of trans people; and 'Othering' processes. Throughout this paper the term 'Othering' refers to the treatment of or the attitude towards a person (or group of people) as fundamentally different from and alien to oneself (Wilkinson and Kitinger 1996).

One participant's view was shaped by both personal and professional experiences of social care provision:

I would feel neither safe nor comfortable approaching a social care agency which deals with domestic abuse... I do not feel that the agencies providing this type of support are yet at a point where they are willing and committed to engaging with trans people and learning about what type of support we need. (Max, genderqueer)

This participant's narrative considered that contemporary practice was shaped by macro-level (structural) forces such as, for example, the Equality Act 2010 which set out the minimum legal requirements for controlling trans people's access to services. The adoption of minimum legal requirements was considered to be inadequate by a number of participants who felt that social care should be underpinned by a commitment to 'best practice' instead (Jones *et al.* 2008).

Several of the participants felt that best practice should not focus upon their gender identity as they had long since transitioned to live in their acquired gender and considered themselves to be women with 'transsexual histories', not trans or 'Other' to male or female (Wilkinson and Kitzinger 1996). Exercising personal agency, these participants had effectively detached their current gender identity from their (trans) gender history. Paradoxically, this created a bind for practitioners working with procedures which relied on binary categories of gender as often these centred on the 'trans' aspect of people's biography in the assessment of eligibility to services (recognised as 'Othering' practices).

At a meso-level (that is, pertaining to community or organisation), the depiction of these 'Othering' practices constituted a barrier to further engagement with the sector. One participant suggested that '[services] don't understand identity needs'. Another suggested that 'many of us experience a lot of transphobia and harassment in our day-to-day lives and come to expect it from services'. However, an alternative view was offered which suggested that the commonplace negative ideation that trans people hold about themselves acted as a barrier to help-seeking

behaviour. People lacked any sense of entitlement as self-beliefs led participants to consider that they were undeserving of help.

Identifying problems linked to ‘Othering’ processes, a participant raised concerns for people who do not conform to normative and binary gender categories or as trans male/female:

I guess the problem would be that most [agencies] would want to categorise me as male...which would make me feel very vulnerable. Not to mention that the majority of services are female-only and tend to exclude even trans women and women with transsexual histories... I would be afraid that the service provider would think it was my fault for being trans, or make my case a low priority because (if) the abuse was related to my gender, considering it to be my 'choice' to come out. (Rachel, genderqueer)

The latter part of this extract refers to the perception that trans is solely a lifestyle choice; an attitude many participants felt would lead to transphobic praxis and would which undermine the very existence of trans identity (Serano 2007). Some participants explored this at a macro-level by identifying the lack of recognition for trans people as citizens in receipt of the rights and responsibilities on a par with non-trans citizens. Some participants considered meso-based concerns and one participant, who had accumulated many years of experience of working across the voluntary and statutory sectors, described the social care sector’s lack of engagement with trans communities as ‘binary fascism’. This ‘binary fascism’ was thought to be scaffolded by ignorance and an inflexibility to move away from binaried thinking.

Barriers to help-seeking behaviour: practitioner’s perspectives

All of the practitioners recognised that the barriers to access for trans survivors were multifaceted and embedded. Exploring the amount of insight of trans identities and practices, the majority of practitioners expressed an awareness of trans although there were common misunderstandings and unfamiliarity with trans-related terminology. Furthermore, endorsing the claims made by trans participants in relation to their experiences of social care, ideas about gender were largely fixed to binary understandings of male and female and, sometimes, this understanding automatically centred on the physical (sexed) body. There were additional misunderstandings, assumptions and attitudes; not necessarily those of professionals. This was highlighted by an independent domestic violence advocate (IDVA), Gloria. Gloria had encountered trans people through her part-time employment in an additional role that supports street-based sex workers. Gloria recalled a trans woman who had experienced harassment from other sex workers when they discovered her trans status:

It became that bad where this woman kind of removed herself from that work on the streets, yeah the trans woman. She left [the city] and, er, we've never seen her again... She couldn't comfortably come out without harassment from the other working women. (Gloria, IDVA)

Gloria's narrative depicted a transphobic response enacted by other 'service users': people who shared a common position and similar vulnerabilities. Whittle *et al.* (2007) identify a (perceived or actual) transphobic response to undergird the reluctance to approach social care services. Gloria also provides another example of 'Othering' processes enacted on a micro (or personal) and meso (within the street community of sex workers) level (Wilkinson and Kitzinger 1996). Another practitioner had considered a potential dilemma resulting from a transitioning

person presenting to services: ‘what would you do if somebody was transitioning... Would you then say ‘alright you’re not entitled to services anymore’?’

Moving the focus from micro to meso conditions, the theme of how space was used by service users and managed by practitioners was deliberated by Gloria. She concluded that it was a matter for ‘policy and practice’. In this framing, Gloria brought attention to an emerging dilemma triggered by trans embodiment when a women-only service is presented with a trans woman who has male physical traits. Gloria’s mapping of the dilemma onto ‘policy and practice’ suggested a ‘safety net’ for decision-making in a move away from, what could be seen as a moral judgement, to one that was bound to and articulated through a written policy. This argument intersects with the criticism from trans participants that social care is usually based upon ‘minimum requirements’ (and not ‘best practice’).

In the context of the domestic abuse sector, it was identified that specific services are problematic in terms of eligibility for trans people who may need refuge accommodation. The shared space of the refuge often encourages therapeutic ‘self-help’ interventions through, for example, group activities and the sharing of experience by co-residents. To this end, a person’s trans status was positioned as potentially problematic in the context of eligibility and the perceived reactions of other service users.

Practitioners recognised the importance of personal circumstances as the question of whether someone was openly living as trans, or not, was a critical issue that needed to be considered. Joan noted that this could be an obstacle to entering supported accommodation:

It's about the physicality. It's about the shared space. It's about whether they want to stay and it not to be known or recognised or whether they would want, you know, to be out for everybody. (Joan, refuge manager)

Eligibility and pathways into service provision were discussed with regard to both referrals from professionals and self-referral routes (which occurred mainly via a domestic abuse helpline). An obstacle to self-referral was identified:

I would imagine there are additional barriers for trans people in picking the phone up and believing that they would get a positive response or an informed, sensitive response through a telephone call. (Helen, multi-agency forum director)

There are fundamental constraints at play in this scenario, as many of the trans participants highlighted, and which relate to gender presentation. Jane (pre-operative transsexual woman) said: 'I hate my voice. I hate hearing my voice'. The ability to pass and its perceived correlate (discrimination) from a trans perspective was recognised as a barrier to service provision, and to citizenship in general.

As previously mentioned, some of the trans participants represented a view that trans people lack a feeling of entitlement to domestic abuse services. Holly (LGBT counsellor) echoed this view when describing how, in her previous role as

a domestic abuse practitioner, she had attempted to understand why trans women did not use the provision offered. Holly explained:

I think barriers are fear of service providers, and fear of (other) clients... most trans women thought that refuges were just for 'women', born women, and that they absolutely feared transphobia and then [they had] this idea that you had to have kids. Almost like the ultimate proof of being a born woman. It's almost like there's this club that they don't belong to. (Holly, LGBT counsellor)

The notion of eligibility was built on assumptions and the gender binary, and this was reproduced through language use. For example, one of the names of the services who contributed to this study was gender-specific; it featured 'young women' in the title. Moreover, nationally a large proportion of domestic abuse services affiliated as Women's Aid organisations maintain the standard name format of 'X Women's Aid'. This use of language effectively conveys the message of eligibility and, it follows, exclusivity.

Some participants reflected on past and contemporary provision within their locality:

When most of the services were women (-only) services, the barrier, I presume, would have been about whether or not the person was perceived to be a woman, a female, to access the service. So, the potential barrier is the question of whether or not the person responding to them perceived them to be a female and that barrier is not there anymore in relation to [community services]. It only applies now to the women's refuges because they are the only services that are for women specifically. (Helen, multi-agency forum director)

However, this is not as straightforward as it seems and Gloria's narrative demonstrates how a trans woman's presence on the street, a site which also represented her work setting, was deemed unacceptable by other sex workers.

Messages for Practice

Reflecting on how meso-level organisations can become subsumed into larger policy initiatives or shifts, one practitioner felt that the domestic abuse sector had undergone significant praxis change as services had been assimilated into a more mainstream framework of public services (Wykes and Welsh 2009). The narratives of practitioners suggested that the demand for gender neutrality (with demands for accommodating male victims/survivors) had become embedded in discourses about good practice and service delivery but with insufficient guidance or resources for effective implementation. Consequentially, it was felt, that the domestic abuse movement has lost its strong political foundation as services are delivered from within the mainstream (and heteronormative) framework for social care provision. Notwithstanding, other participants felt that the sector was still subject to change and that this represented further opportunities to move away from the delimited work based upon the heteronormative model (men = perpetrator, woman = victim/survivor) to address gender-based abuse and violence as a wider concern for adults and children.

The discursive positioning of the domestic abuse movement, as less traditionally feminist, was augmented in other participant's narratives; one participant framed contemporary practice within an 'equality of opportunity' framework whilst

recalling the good work of a male IDVA. The possibility of a male domestic abuse worker, operating alongside female workers and providing services to women who have experienced domestic abuse, was a radical departure from traditional, and the majority of, domestic abuse services. Additionally, the very notion of a male domestic abuse worker demonstrates the potential for a changing domestic abuse discourse and praxis.

Empowering practitioners to support trans survivors was widely agreed to be critical in the pursuit of a framework for practice. This was addressed through the provision of trans equality training by one practitioner; although the benefit of this was temporally fixed and forgotten in the subsequent years as this new knowledge had never been consolidated through practice. Other participants alluded to person-centred practice and models which positioned trans people as ‘experts’ of their experiences (Rogers 1965, Adams *et al.* 2002). Other participants countered the focus on gender difference and reinforced the need for person-centred practice:

I think part of the problem is that [practitioners] don’t know what our needs are and sometimes they think you’ve got different needs. There was a new department head for IT appointed... [It was] my first meeting with him and I said ‘you’ve probably been told I’m transsexual’. He said ‘I’m not sure how I should deal with that’. I said ‘just treat me as another female. That’s what I am’. (Sarah, woman with a transsexual history)

The notion that the use of gendered terminology impeded trans inclusion (and thus inclusive practice) was recognised by many participants. One trans participant reflected upon the need for practitioners to ‘never assume. [Ask] how would you

like to be addressed?’ Accordingly, one practitioner advocated for practice which was based on individual need. She said:

Generally the message we try to get over to [staff] is ‘don’t make assumptions’. Just because someone looks or dresses a certain way, we don’t want that to lead you to making assumptions about what their culture must be, or think ‘they must think this’ or ‘they must be experiencing that’. The important thing is to be doing good assessments and to find out from them, ask them, find out from them what they’re experiencing and what they want. So the same would apply to sexuality or gender. (Helen, multi-agency forum director)

Thus, social care support tailored to the individual, focussing on domestic abuse and safety planning for example, was required.

Discussion

In accord with existing literature, this study found that trans people do not, on the whole, access domestic abuse specialist services, in particular, and social care provision, in general (Fish 2006, Mallon 2009, Mitchell & Howarth 2009, Roch *et al.* 2010, Brown 2011, Hester *et al.* 2012). This claim is partially substantiated through this research as none of the participants had accessed social care and despite the rhetoric of inclusivity, none of the domestic abuse practitioners, or their agencies, had knowingly provided services to trans people.

One participant felt strongly that the onus should be placed upon the social care sector to provide accessible services. However, a misnomer is in operation which promotes the belief that the social care needs of trans people can be best served by specialist LGBT services and, on the whole, trans participants did not specify a

preference to have their needs met by LGBT services. The research findings supported the potential for a narrative model for practice as one participant observed that ‘people are people. You don’t know people’s life stories until you get to know them’. Giddens’s (1991) conception of the self as a ‘reflexive project’ offers some useful insight here as many of the trans participants demonstrated that they were in the process of ‘integrat(ing) events...and sort(ing) them into the ongoing ‘story’ about the self’ (1991, p. 54). Thus, the ontological value of narrative is that it offers potential for social care practitioners to make sense of the world of others as experienced, interpreted and reported by them. Concurrently, a high degree of reflexivity enables practitioners to remain alert to their own narratives and responses. Whilst adopting narrative is relatively straightforward, the challenge lies in doing so within the context of the prevailing heteronormative paradigm. Some participants felt that a paradigm shift was needed to encourage ‘frontline cultures...to change’.

One aim of this study was to identify and explore the barriers to help-seeking behaviour in relation to social care using the specific example of domestic abuse as a focus for exploring the intersectionality of trans identity with contemporary practice. It was found that the barriers are multiple, complex and found at micro, meso and macro levels. Participant narratives demonstrated the entrenched inflexibility of social care agencies to think of gender as an identity, or location, which was not tied to the gender binary; underpinning ideology remained firmly rooted in a model of gender as fixed to male, female or ‘Other’ (Wilkinson and Kitzinger 1996). Yet there has been a considerable amount of pressure placed upon the sector to be gender neutral and to recognise that men are victims too.

However, the government's approach to 'gender neutrality' does not necessarily reflect gender diversity or incorporate the trans perspective. As such, the praxis of the organisations represented in this study did not reflect policy and practice which acknowledged the uniqueness and particularity of trans communities and their presenting needs in the context of domestic abuse. Notwithstanding, there was a clear commitment demonstrated by individuals and their agencies in relation to improving accessibility.

Limitations of the Study

Due to the size of the study, claims of generalisability are made with caution. Notwithstanding, the academic literature on this subject is scant and so the value of this contribution is that it adds to a small body of work in a number of thematic areas: domestic abuse; social care and social work; gender theory. Another consideration is that each narrative represents a discursive production which is very much fixed, not only to that person's interpretation of their experience, or their role and practice setting, but to a certain point in time and space. Temporal and spatial contexts are particularly cogent here as there is great disparity in domestic abuse service provision throughout the UK. Any snapshot of provision should be considered as subject to change as a consequence of current austerity measures and fluctuating state funding (Coy *et al.* 2009).

Recommendations for Practice

The main indications and recommendations for practice are as follows:

1. Trans people have their gender identity needs met through existing networks (for example, friendships or the virtual trans community) or

through their engagement with the medical sector. Therefore, domestic abuse agencies should centre on meeting the social care needs connected to experiences of domestic abuse only.

2. The research findings supported the potential for a more person-centred, narrative model for practice. Language and discursive practice are at the root of narrative approaches which encourage service users to tell their stories (Wilks 2005, Baldwin 2013). This type of strategy should promote practice which resists categorising people and which focuses on the individual.
3. It was felt that the sector would benefit from written guidance for professionals working with trans survivors which was underpinned by best practice, not minimum legal standards, and which was enhanced by trans awareness training. Trans participants felt that this type of activity would promote an ideological shift and a more fluid attitude towards trans and gender non-conformity. One participant suggested that ‘one thing that would make a difference is if an agency actively promoted itself as trans positive’.

Conclusion

In the above discussion, the question of providing specialist social care provision to trans people experiencing domestic abuse was raised. Moving away from the consuming focus on gender identity, both participants and practitioners brought a grounded perspective to this question by advocating for domestic abuse provision accessible to all. This is the argument that I make here: domestic abuse practitioners hold the expertise to work with trans people who experience

domestic abuse. Expertise, in this framing, comprises empirical knowledge and skills, although the value of this expertise can be restricted by the relentless issue of under-resourcing (Coy *et al.* 2009). Additionally, since the emergence of the domestic abuse movement, there have been numerous changes to the socio-cultural-political climate, however, time and time again, the sector has responded to emergent issues arising from differentiated cultural enactments of domestic abuse (for example, female genital mutilation (FGM), or 'honour'-based killings). These claims are made using the empirical data (which found that all practitioners who participated in the study were deeply insightful and person-centred practitioners) and by drawing upon my professional experience as a practitioner with over fifteen years experience of working within the domestic abuse sector. Thus, as the domestic abuse sector has a history of responsiveness and flexibility, this study suggests that the sector is best placed to provide social care support to trans survivors of domestic abuse provided that the infrastructure is strengthened and the influence of heteronormativity is acknowledged and responded to.

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